

San Diego Sexual Medicine

PATIENT REGISTRATION

Your paperwork must be completed upon arrival for your appointment.

Patient Name _____ Date _____
First Middle Last

Social Security Number _____ - _____ - _____ Birth Date _____

Marital Status Single _ Married ___ Widowed ___ Sex Female ___ Male ___

Mailing Address Street _____
City/State _____ Postal Code _____ Country _____

Phone(s) (H) _____ (W) _____ (C) _____

Preferred number: H / W / C E-mail address _____

I prefer that messages be given by: phone [] e-mail [] mail []

Occupation _____ Employer _____

Highest level of Education _____ Race _____ Ethnicity _____

Name of Emergency Contact _____
First Middle Last

Relationship to Patient _____ Phone(s) _____

CONDITIONS OF REGISTRATION

IMPORTANT, PLEASE NOTE: If the patient is incompetent, a legal guardian or conservator must sign.

MEDICAL CONSENT: The undersigned consents to medical examination, treatment, laboratory procedures and x-ray studies ordered by physician(s)/provider(s).

RELEASE OF INFORMATION: If you are found to have a condition that must be reported to a county, state or national health agency, your diagnosis will be reported as required by law to the appropriate agency.

FINANCIAL AGREEMENT: All facility charges are due and owing at discharge. In consideration of the services to be rendered, to the extent not expressly prohibited by law, I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE SAN DIEGO SEXUAL MEDICINE, APC AT THE USUAL AND CUSTOMARY CHARGE OF THE FACILITY. I hereby waive all claims of exemption. SDSM may check and/or verify all patient's/responsible party's reference and financial information.

AUTHORIZATION TO TRANSFER FUNDS: Should a credit balance appear on the patient's account with SDSM during the course of care for the patient, the patient/responsible party authorizes use of the credit balance to pay any unpaid balance on any other accounts.

CAUTION; DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

The undersigned certify they have read the foregoing, received a copy thereof, and accept its terms.

Patient or Patient's Agent, Representative or Responsible Party Date

I personally guarantee the financial obligation indicated by the financial terms set forth above.

Co-signer/Responsible Party Date

Witness Date

San Diego Sexual Medicine

Director: Irwin Goldstein, MD
6719 Alvarado Road, Suite 108
San Diego, CA 92120
P: 619.265.8865 F: 619.265.7696

**CONSENT
PLEASE READ AND SIGN THE FOLLOWING:**

We often get inquiries from family members and friends about the status of our patients. Please be advised that due to Federal Law, we will not release any information about our patients without their prior written consent. Please indicate below how you would like to disclose your information.

_____ Do NOT release any information to anyone other than myself.

_____ You may release information ONLY to the following person(s):

_____	_____	_____
Name	Relationship to Patient	Phone Number

_____	_____	_____
Name	Relationship to Patient	Phone Number

_____	_____	_____
Name	Relationship to Patient	Phone Number

_____	_____	_____
Name	Relationship to Patient	Phone Number

_____	_____
Signature	Date

San Diego Sexual Medicine

AUTHORIZATION FOR RELEASE OF RECORDS

To: San Diego Sexual Medicine
Irwin Goldstein, MD
Mary M. Clark, PhD
6719 Alvarado Road, Suite 108
San Diego, CA 92120
Phone: 619 265-8865
Fax: 619 265-7696

Patient's Name: _____

Address: _____

Phone: _____ Date of Birth: _____

I hereby authorize the release of my medical records, which should include:

I request that these records be sent to:

Name

Address

Phone

Fax

Signature: _____ Date: _____

Patient's Name: _____ Date: _____

I found out about Dr. Goldstein and/or San Diego Sexual Medicine from:

- Referral
- The internet
- Television/radio _____
- A newspaper/magazine _____
- A book _____

I was referred to:

- Dr. Irwin Goldstein
- Sexual Medicine at Alvarado Hospital
- San Diego Sexual Medicine

I was referred by:

- My primary care physician
- A physician specializing in _____
- A friend or relative
- Self-referral

Information regarding referring physician:

Name: _____ Phone: _____

Address: _____

I would like Dr. Goldstein to send detailed information regarding my visit to my referring physician.

- Yes No

Information regarding primary care physician:

Name: _____ Phone: _____

Address: _____

I would like Dr. Goldstein to send detailed information regarding my visit to my primary care physician.

- Yes No

San Diego Sexual Medicine
MEDICAL HISTORY – PART I

Name: _____ Date: _____

Date of birth: _____ Age: _____ Height: _____ Weight: _____

Married _____ yrs Monogamous Relationship _____ yrs Divorced Single Widowed

Major childhood illnesses: _____

Medications: _____

_____ Drug allergies: _____
Food allergies _____ Latex allergy: _____

Have you ever had any of the following medical conditions? *(Check all that apply)*

- | | |
|-------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neurologic disease (e.g. MS) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Genital conditions _____ |

Family history of any of the above conditions:

- | | |
|------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Neurologic disease (e.g. MS) |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Urinary tract disease | <input type="checkbox"/> Incontinence |

Cancer: Type _____ Treatments: _____

Previous surgeries: Type and Date _____

Other medical disorders: _____

Depression Other psychological disorders: _____

Current smoker? Y / N _____ yrs Have you ever smoked? Y / N _____ packs/day

Do you ever drink alcohol? Y / N _____ drinks/day

Do you use any recreational drugs (marijuana, cocaine, heroin, etc.): Y / N

Please describe: _____

Military service Criminal history _____

What best describes **the most frequent condition** of your penis during sexual activity over the last four weeks?

- 1. Penis is larger but not hard
- 2. Penis is hard but not hard enough for penetration
- 3. Penis is hard enough for penetration but not completely hard
- 4. Penis is completely hard and fully rigid

Have you ever had any of the following medical conditions? *(Check all that apply)*

- | | |
|-------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Genitourinary conditions | <input type="checkbox"/> Testicular conditions |
| <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Epididymal conditions |
| <input type="checkbox"/> Abnormal urethral discharge | <input type="checkbox"/> Scrotal conditions |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Prostate conditions |
| | <input type="checkbox"/> Vasectomy |

San Diego Sexual Medicine

MEDICAL HISTORY – PART II

Name: _____

Date: _____

Past Medical Evaluation

- | | | | |
|---------------|------------------------|------------------------------|-----------------------------|
| Have you had: | Hormones evaluated | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Physical trauma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Trauma to your pelvis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Perineum tissue injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Trauma to the penis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Past Sexual Treatments (*Check all that apply*)

- | | | |
|---------------------------------|------------------------------|-----------------------------|
| Diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Regular exercise | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Medication changed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pelvic floor stimulation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vibrator needed to reach orgasm | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sex Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Counseling | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| CBT | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cialis, Levitra, Viagra | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Testosterone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clomiphene citrate | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arimidex | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dopamine agonists | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vacuum erection device | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| MUSE | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Injections | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Penile prosthesis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Penile revascularization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Peyronie's/curvature correction | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SEXUAL HISTORY – PART I

Name: _____

Date: _____

Describe your sexual problem(s): _____

Please choose the number that best describes **the most frequent condition** of your penis during sexual activity over the last four weeks: _____

- _____ 1. Penis is larger but not hard
- _____ 2. Penis is hard but not hard enough for penetration
- _____ 3. Penis is hard enough for penetration but not completely hard
- _____ 4. Penis is completely hard and fully rigid

Vasectomy? Y / N Date _____ Nocturnal Emissions? Y / N Age of onset _____

Compared to peak sexual function:

penile rigidity _____% sustaining capability _____% spontaneity _____%

Compared to peak sexual function morning erections are present/absent rigidity _____%

Ejaculation: normal _____ early _____ delayed _____

Approximate time from average penetration to ejaculation: _____ minutes

Is your erect penis curved? Y / N Direction: _____ Angle: _____

Does this affect your ability to have intercourse? Y / N Does this cause pain to your partner? Y / N

Present intercourse success rate: _____% Frequency of intercourse: _____

Age range at peak sexual function: _____

Rate your sexual function at peak function at present 0-100%

Desire/interest _____

Arousal/Erection _____

Orgasm/Ejaculation _____

Sexual/genital pain? Y / N Years: _____

Location: _____

Description: _____

Triggered by: _____

Made worse by: _____

Made better by: _____

To what do you attribute your sexual dysfunction? *Circle all that may apply*

Injuries Surgery Sexual abuse Medications: _____

Other: _____

Have you had penile trauma in erect state (crack sound during partner superior sexual intercourse)? Y / N

Describe: _____

Have you ever fallen on your crotch on a hard object? (bicycle bar, fence) Y / N

Describe: _____

Are you a bike rider? Y / N Are you a horse rider? Y / N

How long/often: _____ How long/often: _____

Previous diagnostic tests for your sexual problem: _____

Previous psychologic treatments for your sexual problem: _____

Previous medical treatments for your sexual problem: _____

Have a sexual partner? Yes / No Does partner have sexual problems? Y / N Please explain: _____

SEXUAL HISTORY – PART II

Name: _____ Date: _____

Age: _____ DOB: _____ Religion (Child) _____ (Present) _____

Presenting complaint: _____

Substance Use: _____

Abuse: _____

Earliest childhood memory: _____

Earliest sexual memory: _____

Whose idea was it: _____ Why did you agree: _____

Masturbation: Age _____ Were you ever sexually seduced, molested, or raped as a child? Yes No

Age when sexually active: _____ Age of partner: _____

Sex Education: Where _____ By whom _____

Favorite sexual fantasy: Sex of partner M F Age of partner: _____

Act(s) _____

Long term relationships including patient's and partner's ages:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Reason for commitment:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Reason for divorce or separation:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

On a scale of 0 - 10 (terrible = 0, 10 = perfect) rate each relationship:

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

What would have improved it:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

What stimulates you: _____

Erotic responses: _____ Orgasmic: _____

How do you stimulate your partner: _____

Name: _____ Date: _____

Use of force: _____

How do you feel about your sexual orientation: _____

History of Sexual Pattern

Gender/Age Preference: _____ Exhibitionism _____ Sexual masochism _____

_____ Fetishism _____ Sexual sadism _____

Times/Week: _____ Frotterurism _____ Transvestic Fetish _____

_____ Pedophilia _____ Voyeurism _____

Who initiates: _____ Paraphilia NOS _____ Other _____

What acts: _____

Nocturnal seminal emissions/frequency: _____

Definition of love: _____

Self-concept: what do you

consider your best quality: _____

consider your greatest weakness: _____

like best about present partner: _____

see as major problem that brought you to therapy: _____

think would be of greatest help to you: _____

Comments: _____

Diagnosis: _____
